Division of Licensing and Protection
HC 2 South, 280 State Drive
Waterbury, VT 05671-2060
http://www.dail.vermont.gov
Survey and Certification Voice/TTY (802) 241-0480
Survey and Certification Fax (802) 241-0343
Survey and Certification Reporting Line: (888) 700-5330
To Report Adult Abuse: (800) 564-1612

October 23, 2017

Ms. Lynn Keyes,
Lenny Burke's Farm, Inc.
Po Box 75
Wallingford, VT 05773

Dear Ms. Keyes:

Enclosed is a copy of your acceptable plans of correction for the survey conducted on August 15, 2017. Please post this document in a prominent place in your facility.

We may follow-up to verify that substantial compliance has been achieved and maintained. If we find that your facility has failed to achieve or maintain substantial compliance, remedies may be imposed.

Sincerely,

Pamela M. Cota, RN
Licensing Chief

PRINTED: 09/05/2017
FORM APPROVED

Division of Licensing and Protection

SEP 18 2017

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0061	A. BUILDING: _____ B. WING _____	C 08/15/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LENNY BURKE'S FARM, INC.	PO BOX 75 WALLINGFORD, VT 05773

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
R100	Initial Comments: An unannounced onsite re-licensure survey and complaint investigation were conducted on 8/15/17 by the Division of Licensing and Protection. The following regulatory deficiencies were identified as a result of the survey and the investigation:	R100		
R104 SS=A	V. RESIDENT CARE AND HOME SERVICES 5.1 Admission 5.2.a Prior to or at the time of admission, each resident, and the resident's legal representative if any, shall be provided with a written admission agreement which describes the daily, weekly, or monthly rate to be charged, a description of the services that are covered in the rate, and all other applicable financial issues, including an explanation of the home's policy regarding discharge or transfer when a resident's financial status changes from privately paying to paying with SSI or ACCS benefits. This admission agreement shall specify at least how the following services will be provided, and what additional charges there will be, if any: all personal care services; nursing services; medication management; laundry; transportation; toiletries; and any additional services provided under ACCS or a Medicaid Waiver program. If applicable, the agreement must specify the amount and purpose of any deposit. This agreement must also specify the resident's transfer and discharge rights, including provisions for refunds, and must include a description of the home's personal needs allowance policy. (1) In addition to general resident agreement requirements, agreements for all ACCS	R104	• ALL FINANCIAL ISSUES ARE NOW INCLUDED IN CURRENT ADMISSION AGREEMENTS AND RE-SIGNED BY RESIDENTS / GUARDIANS. • ALL FUTURE AGREEMENTS WILL INCLUDE THAT INFO FOR NEW ADMISSIONS • THERE ARE NO DEPOSITS FOR ANY RESIDENTS	

Division of Licensing and Protection
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: M. Burke TITLE: Licensee (X6) DATE: 9/14/17

R104 - R224 POC accepted 10/19/17 mHigginsRN | PMC

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R104	Continued From page 1 participants shall include: the ACCS services, the specific room and board rate, the amount of personal needs allowance and the provider's agreement to accept room and board and Medicaid as sole payment. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview the facility failed to assure that a signed admission agreement was present for one of three residents reviewed, Resident #2 (R#2). Findings include: Per record review, the Admission Agreement for R#2 has no signature. Notations on the present Admission Agreement state that the resident refuses to sign the agreement. In an interview on 8/15/17 at 11:30 AM, the facility Manager stated that no other admission agreements were available for this resident.	R104	D NOW SIGNED AND INITIALED	
R114 SS=D	V. RESIDENT CARE AND HOME SERVICES 5.3 Discharge and Transfer Requirements 5.3.a Involuntary Discharge or Transfer of Residents (2) In the case of an involuntary discharge or transfer, the manager shall: i. Notify the resident, and if known, a family member and/or legal representative of the resident, of the discharge or transfer and the specific reasons for the move in writing and in a language and manner the resident understands at least 72 hours before a transfer within the	R114		

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R114	Continued From page 2 home and thirty (30) days before discharge from the home. If the resident does not have a family member or legal representative and requests assistance, the notice shall be sent to the Long Term Care Ombudsman, Vermont Protection and Advocacy or Vermont Senior Citizens Law Project. ii. Use the form prescribed by the licensing agency for giving written notice of discharge or transfer and include a statement in large print that the resident has the right to appeal the home's decision to transfer or discharge with the appropriate information regarding how to do so. iii. Include a statement in the written notice that the resident may remain in the room or home during the appeal. iv. Place a copy of the notice in the resident's clinical record. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview the facility failed to provide to the resident/legal representative the required written notice of involuntary discharge and appeal rights for one resident, Resident #1 (R#1). Findings include: Per record review, R#1 was involved in an incident on 8/4/17 and the Vermont State Police responded. R#1 was transported to Rutland Regional Medical Center (RRMC) where s/he was admitted. The facility Manager stated, in an interview 8/15/17, that R#1 and the legal representative were issued an involuntary discharge verbally. The notice occurred in a phone call on the night of the incident. The	R114	THIS SITUATION WAS ADDRESSED IN A SERIES OF FORMAL MEETINGS WITH THE RESIDENT, HIS LEGAL GUARDIAN, AND THE STATE OMBUDSMAN FULL TEAM MEETINGS WERE HELD WITH ABOVE PARTIES, AS WELL AS MANAGER AND LICENSEE ON 5/31/17 AND 6/17/17, 7/17/17 WITH FOLLOW-UP SCHEDULED FOR 9/7/17 LICENSEE EMAILED THE OMBUDSMAN AND LEGAL GUARDIAN AT 2PM ON 8/3/17 TO EXPRESS CONCERNS AND THEN WHEN THE SITUATION OCCURRED LICENSEE EMAILED GUARDIAN AND OMBUDSMAN AT 2:30 AM 2:30 AM EMAIL IS AVAILABLE FOR SURVEYOR REVIEW IF NEEDED	

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R114	Continued From page 3 Manager confirmed in the interview, that no written notice was provided to the resident or legal representative.	R114	LICENSEE INTENDED EMAIL AS WRITTEN NOTICE • IN THE FUTURE IF THIS WERE TO OCCUR THE IMMEDIATE EMAIL WOULD BE FOLLOWED UP BY LETTER IN WRITING	
R116 SS=A	V. RESIDENT CARE AND HOME SERVICES 5.3 Discharge and Transfer Requirements 5.3.b Emergency Discharge or Transfer of Residents (1) An emergency discharge or transfer may be made with less than thirty (30) days notice under the following circumstances: i. The resident's attending physician documents in the resident's record that the discharge or transfer is an emergency measure necessary for the health and safety of the resident or other residents; or ii. A natural disaster or emergency necessitates the evacuation of residents from the home; or iii. The resident presents an immediate threat to the health or safety of self or others. In that case, the licensee shall request permission from the licensing agency to discharge or transfer the resident immediately. Permission from the licensing agency is not necessary when the immediate threat requires intervention of the police, mental health crisis personnel, or emergency medical services personnel who render the professional judgement that discharge or transfer must occur immediately. In such cases, the licensing agency shall be notified on the next business day; or iv. When ordered or permitted by a court	R116		

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R116	Continued From page 4 This REQUIREMENT is not met as evidenced by: Based on staff interview, the facility failed to notify the licensing agency by the next business day that an emergency involuntary discharge had occurred for Resident #1. Findings include: Per interview, on 8/15/17 at 11:45 AM, the Licensee/Co-owner stated that an emergency involuntary discharge was given to Resident #1 because the responding police officer informed them that the resident could not return to the facility due to the pending charges. S/he also stated that no report of the emergency discharge had been made to the Division of Licensing & Protection (DLP).	R116	LICENSEE NOTIFIED CANADIAN, STATE OMBUDSMAN AND MEDICAID OF THE DISCHARGE BUT DID NOT TAKE THE ADDITIONAL STEP OF NOTIFYING LICENSING BEYOND THE OMBUDSMAN CORRECTIVE ACTION INVOLVES LICENSEE/MANAGER ASSURING THAT THEY WILL FOLLOW ALL STEPS TAKEN AND ALWAYS NOTIFYING LICENSING DIRECTLY IMMEDIATELY	
R136 SS=A	V. RESIDENT CARE AND HOME SERVICES 6.7 Assessment 6.7.c Each resident shall also be reassessed annually and at any point in which there is a change in the resident's physical or mental condition. This REQUIREMENT is not met as evidenced by: Based on record review and interview, the facility failed to assure that annual reassessments were completed for 2 residents of 3 reviewed, Residents #2 & #3. Findings include: Per record review, Resident #2 had an annual assessment in the record for the year 2015. The	R136		

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R136	Continued From page 5 assessment did not contain an RN signature of review/ completion. Per record review Resident #3 had an annual assessment in the record for the year 2015. The assessment did not contain an RN signature of review/ completion. In a telephone call on 8/17/17 the Licensee confirmed that the assessments provided were the only assessments available.	R136	ALL RESIDENT ASSESSMENTS HAVE BEEN COMPLETED AND SIGNED BY RN. THE UN-SIGNED DOCUMENTS WERE COMPLETED BY RN, BUT INADVERTENTLY NOT SIGNED. IT WAS ESSENTIALLY A CLERICAL ADMISSION. MANAGER AND STAFF ARE WORKING CLOSELY WITH RN AND ASSURE THAT ALL FUTURE AND ONGOING ASSESSMENTS WILL BE SIGNED UPON COMPLETION BY RN	
R145 SS=D	V. RESIDENT CARE AND HOME SERVICES 5.9.c (2) Oversee development of a written plan of care for each resident that is based on abilities and needs as identified in the resident assessment. A plan of care must describe the care and services necessary to assist the resident to maintain independence and well-being; This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews the facility failed to assure that each resident has a plan of care which describes the care and services necessary to assist the resident to maintain independence and well-being for 2 residents of 3 reviewed (R#1 & R#2). Findings include: Per record review, R#1 had numerous complaints, has called 911 and has pulled the fire alarm as well. S/he also was sent to the	R145		

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R145	Continued From page 6 Emergency Room of the local hospital twice and complained of being "attacked" by another resident. In a review of his/her plan of care it does state that s/he has these behaviors, as well as being threatening to staff. It was also stated that on one occasion s/he picked up a knife to threaten staff. There is nothing found in his/her plan of care regarding increased monitoring, frequent safety checks, keeping sharp objects protected, or interventions to redirect and de-escalate his/her agitation. In an interview on 8/15/17 the Manager stated that this resident, though complaining about being targeted, was the aggressor toward R#2. S/he stated that R#1 would stare at R#2 and watch him/her. In the first incident s/he walked into the bathroom while R#2 was using it. On another occasion R#1 stood outside the door of R#2's room. On the night of the last incident R#1 went downstairs to R#2's room and was found physically attacking him/her. Staff had a difficult time separating the residents and the police were called. Per staff interview on 8/15/17, the Manager stated that R#2 had begun staying in his/her room related to R#1's behaviors. In a review of R#2's plan of care there, is no intervention listed or found regarding increased safety monitoring, safety checks, or maintaining a safe distance between residents. In interview the Manager stated that the resident was being targeted by R#1 and that the resident had begun to stay in his/her room more to try to avoid contact. There is no revision of the care plan to reflect maintaining safety for the resident. There are no interventions found for increased	R145	THIS SITUATION WAS ADDRESSED WITH A FULL TEAM APPROACH WITH THE RESIDENT, HIS LEGAL GUARDIAN, AND THE STATE OF VERMONT OMSBUDSMAN. TEAM MEETINGS WERE HELD 5/31/17 6/17/17, 7/17/17 WITH A FOLLOW-UP SCHEDULED FOR 9/7/17. AT EACH MEETING INFORMATION WAS SHARED AND ALL STAFF WAS APPRISED OF PRE-CAUTIONARY SAFETY MEASURES TO AVOID CONFLICT BETWEEN THE 2 COGNITIVELY AND BEHAVIORALLY CHALLENGED RESIDENTS. RN WAS INCLUDED, AND	

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R145	Continued From page 7 monitoring, safety checks, keeping residents separated, and providing socialization opportunities. See also R224.	R145	SCHEDULED TO ATTEND PHYSICIAN (PSYCHIATRIST) APPOINTMENT. ALTHOUGH THE ACTUAL CARE PLAN WAS NOT REFLECTIVE, STAFF THROUGH A DAILY COMMUNICATION LOG, AS WELL AS THROUGH FACE TO FACE MEETINGS WITH BOTH RN AND SENIOR STAFF, WERE APPRISED OF THE SITUATION AND GIVEN TECHNIQUES TO PROVIDE SAFETY FOR BOTH INCIDENTS. CORRECTIVE ACTION WILL INCLUDE UPDATING CARE PLANS TO INCLUDE DAILY LOG INFO AND LICENSEE WILL BE NOTIFIED BEYOND STATE OMBUDSMAN	
R150 SS=D	V. RESIDENT CARE AND HOME SERVICES 5.9.c (7) Assure that symptoms or signs of illness or accident are recorded at the time of occurrence, along with action taken; This REQUIREMENT is not met as evidenced by: Based on record review the facility failed to assure that incidents are recorded at the time of occurrence, along with action taken for 2 residents of 4 reviewed. Findings include: Per a review of the records of both R#1 & R#2 there is not sufficient documentation to fully describe the extent and frequency of the behaviors of R#1 and the described impact upon R#2. In a review of the care plans of both R#1 & R#2 there is no update with interventions regarding increased monitoring, safety checks, interventions to redirect and de-escalate behaviors, and separation of the two residents. In a review of his/her plan of care it does state that s/he has these behaviors as well as being threatening to staff. See also R224.	R150		
R181 SS=D	V. RESIDENT CARE AND HOME SERVICES	R181		

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R181	Continued From page 8 5.11 Staff Services 5.11.d The licensee shall not have on staff a person who has had a charge of abuse, neglect or exploitation substantiated against him or her, as defined in 33 V.S.A. Chapters 49 and 69, or one who has been convicted of an offense for actions related to bodily injury, theft or misuse of funds or property, or other crimes inimical to the public welfare, in any jurisdiction whether within or outside of the State of Vermont. This provision shall apply to the manager of the home as well, regardless of whether the manager is the licensee or not. The licensee shall take all reasonable steps to comply with this requirement, including, but not limited to, obtaining and checking personal and work references and contacting the Division of Licensing and Protection in accordance with 33 V.S.A. §6911 to see if prospective employees are on the abuse registry or have a record of convictions. This REQUIREMENT is not met as evidenced by: Based on record reviews and staff interview the facility failed to take steps to assure that no staff person has had a charge of abuse, neglect or exploitation substantiated against him or her. Findings include: Per record review of 5 randomly chosen staff, 1 staff member was found to be missing a required child abuse registry record check. In an interview the Manager confirmed that there was no child abuse registry record check available for this employee.	R181	LENNY BURKE'S FARM ALWAYS PERFORMS THOROUGH BACK GROUND CHECK THIS EMPLOYEE HAD PASSED ADULT PROTECTIVE AND CRIMINAL BACK GROUND CHECKS AND THESE WERE ON FILE AND PRESENTED TO SUPERVISOR. A CHILD CHECK WAS SUBMITTED CONCURRENTLY (2005) AND RETURNED FOR SIGNATURE - AND INADVERTENTLY FILED AS COMPLETE	

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R208	Continued From page 9	R208	A NEW CHECK WAS SUBMITTED AND CAME BACK FINE. (8/17) CORRECTIVE ACTION HAS ALREADY TAKEN PLACE WITH ALL LONG-STANDING EMPLOYEE FILES REVIEWED AND FOUND TO BE IN ORDER WITH ALL CHECKS COMPLETE.	
R208 SS=A	V. RESIDENT CARE AND HOME SERVICES 5.18 Reporting of Abuse, Neglect or Exploitation 5.18.c Incidents involving resident-to-resident abuse must be reported to the licensing agency if a resident alleges abuse, sexual abuse, or if an injury requiring physician intervention results, or if there is a pattern of abusive behavior. All resident-to-resident incidents, even minor ones, must be recorded in the resident's record. Families or legal representatives must be notified and a plan must be developed to deal with the behaviors This REQUIREMENT is not met as evidenced by: Based on staff interviews the facility failed to assure that all resident allegations of abuse and patterns of abusive behavior are reported to the state agency. Findings include: Per record review R#1 had numerous complaints, has called 911 and has pulled the fire alarm as well. S/he also was sent to the ER twice and complained of being "attacked" by another resident. In an interview on 8/15/17, the Manager stated that this resident, though complaining about being targeted, was the aggressor toward R#2. S/he stated that R#1 would stare at R#2 and watch him/her. In the first incident s/he walked into the bathroom while R#2 was using it. On another occasion R#1 stood outside the door of R#2's room. On the night of the last incident, R#1 went downstairs to R#2's room and was found physically attacking him/her. Staff had a difficult time separating the residents and the police were called.	R208	THIS SITUATION WAS ADDRESSED WITH A SERIES OF TEAM MEETINGS, SUPPORT FROM RN, AS WELL AS STRATEGY SESSIONS AMONGST MANAGERS, LICENSEE, AND STAFF TO PROVIDE A SAFE, SECURE AND QUALITY ENVIRONMENT FOR BOTH (ALL) RESIDENTS.	

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R208	Continued From page 10 In staff interview the Manager and Licensee confirmed that no reports of the allegations of R#1 and incidents between R#1 & R#2 had been made to the state agency.	R208		
R224 SS=D	VI. RESIDENTS' RIGHTS 6.12 Residents shall be free from mental, verbal or physical abuse, neglect, and exploitation. Residents shall also be free from restraints as described in Section 5.14. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview the facility failed to assure that one resident R#2 was free from verbal and/or physical abuse. Findings include: Per record review, R#1 had numerous complaints and called 911 and pulled the fire alarm as well. Staff states that these calls began shortly after admission and continued for weeks. Also, R#1 often complained of medical issues and requested that s/he also was sent to the Emergency Room (ER) twice and complained of being "attacked" by another resident. It was also stated that on one occasion s/he picked up a knife to threaten staff. The date of this incident is unclear but after the incident the staff attempted to secure the kitchen and monitor R#1 when he was in that area. In a review of the records of both R#1 & R#2 there is not sufficient documentation to fully describe the extent and frequency of the behaviors of R#1 and the described impact upon	R224	R2 IS FINE AND SAFE AND HAS BEEN EXAMINED BY RN WITH NO UNDUE EFFECTS NOTED. STAFF WAS VERY PROACTIVE REGARDING PROVIDING INFORMATION TO RN AND CO-WORKERS ABOUT HEALTH AND SAFETY SUPERVISION AND WORKING TOGETHER TO PROVIDE SAFETY AND QUALITY. IN THE FUTURE CORRECTIVE ACTION WILL INCLUDE NOTIFYING LICENSING BEYOND STATE OMSBUDSMAN OF THE NOTED CONFLICTS	

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LENNY BURKE'S FARM, INC.	PO BOX 75 WALLINGFORD, VT 05773

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
R224	Continued From page 11 R#2. In a review of the care plans of both R#1 & R#2 there is no update with interventions regarding increased monitoring, safety checks, interventions to redirect and de-escalate behaviors, and separation of the two residents. In a review of his/her plan of care it does state that s/he has these behaviors as well as being threatening to staff. In an interview on 8/15/17 the Manager stated that this resident, though complaining about being targeted, was the aggressor toward R#2. In the first incident in which R#1 went to the local hospital, on 7/2/17, the staff found that though R#1 alleged s/he had been attacked, that s/he had entered the bathroom after R#2 was already in there and R#1 was the aggressor. Both residents received scratches during the altercation. S/he stated that R#1 would stare at R#2, and watch him/her. On another occasion, shortly after the incident on 7/2/17, R#1 stood outside the door of R#2's room. R#1's behavior was very upsetting to R#2, and it is stated that R#1 often would just sit and stare at R#2. On the night of the last incident, 8/4/17, R#1 went downstairs to R#2's room and was found physically attacking him/her. Staff had a difficult time separating the residents and the police were called. At that time the police charged R#1 with assault and transported him/her to the ER. The Manager states that R#2 began isolating in his/her room and that after R#1 left s/he began coming out more often. In an interview R#2 states s/he doesn't want to talk about the incidents or R#1.	R224	ALL STAFF WERE PROVIDED WITH ONGOING TRAINING, SUPPORT AND STAFF TECHNIQUES TO PROVIDE SAFETY AND QUALITY TO BOTH (ALL) RESIDENTS. STAFF DID AN EXCELLENT JOB OF DETERMINING THE SOURCE OF THE CONFLICT(S) AND WERE ABLE TO KEEP R2 SAFE (AS DOCUMENTED BY RN) CORRECTIVE ACTION WILL INCLUDE CONTINUED COMMUNICATION AND TRAINING, AS WELL AS ASSURING THAT CARE PLANS ARE UPDATED TO INCLUDE INFORMATION FROM STAFF LOGS, TEAM MEETINGS, AND STAFF TECHNIQUES AND STRATEGIES TO PROVIDE SAFETY + QUALITY	